Name Reward R

AUG 19 2020

RECEIVED

LaSalle Corrections Southeast

MEDICAL REQUEST & CONSENT FOR TREATMENT FORM

Date 08-16-20

Inmate/Detainee Name Andrea Manique J. ID Number 64401

Unit C1 Date of Birth [redacted]

MEDICAL REQUEST

Any Allergies to Medication: N/A

Nature of Medical Complaint: I need my Medical Record please. Thank you!

CONSENT TO TREATMENT:

By signing below, I hereby grant authority to administer and perform routine examinations, treatments of minor illnesses and injuries, medications and diagnostic procedures which may be necessary to address my above medical complaint by physicians, dentists, registered nurses or psychiatrists serving as contract providers or referral. This consent also releases my medical/dental record in whole or part to any outside consultants providing treatment or other services on a referral basis. I also understand that I may be charged a co-pay for medical treatment, which will be withdrawn from my account. I reserve the right to refuse treatment at any time.

Inmate/Detainee Signature _____ Date _____

To Be Completed By Medical Staff Only (Where Applicable)

Staff Response: _____

Subjective: _____

Objective: _____

Assessment: _____

Plan: Take request for records to D/T

Medical Staff Signature: T Hughes, LPN Date: 8-19-20

EXHIBIT E

Name: [illegible]

JUL 30 2020

RECEIVED

SOLICITUD MÉDICA Y CONSENTIMIENTO PARA EL FORMULARIO DE TRATAMIENTO

Fecha 07/30/2020.

Nombre del recluso / detenido Manrique-Yanez, Andrea Número de identificación 64401

Unidad G4 Fecha de nacimiento [redacted]

SOLICITUD MÉDICA

Cualquier alergia a la medicación: _____

Naturaleza de la Queja Médica: I have received therpy for my back/spine pain. Its been a long time, I can't stand the pain Its extreme. Please help. I need to see a specalist.

CONSENTIMIENTO PARA EL TRATAMIENTO:

Al firmar a continuación, otorgo autoridad para administrar y realizar exámenes de rutina, tratamientos de enfermedades y lesiones menores, medicamentos y procedimientos diagnósticos que pueden ser necesarios para tratar mi queja médica anterior por médicos, dentistas, enfermeras registradas o psiquiatras que actúan como proveedores contractuales o remisión. Este consentimiento también libera mi expediente médico / dental en totalidad o en parte a cualquier consultor externo que proporcione tratamiento u otros servicios sobre una base de referencia. También entiendo que se me puede cobrar un copago por tratamiento médico, el cual será retirado de mi cuenta. Me reservo el derecho de rechazar el tratamiento en cualquier momento.

Firma del recluso / detenido _____

To Be Completed By Medical Staff Only (Where Applicable)

Staff Response: _____

Subjective: _____

Objective: _____

Assessment: _____

Plan: _____

Medical Staff Signature: _____ Date: _____

Name: [illegible]

LaSalle Corrections Southeast

JUL 01 2020

RECEIVED

MEDICAL REQUEST & CONSENT FOR TREATMENT FORM

Date 6/29/20

Inmate/Detainee Name Andrea Manrique ID Number 64401

Unit 64201 Date of Birth [redacted]

MEDICAL REQUEST

Any Allergies to Medication NO

Nature of Medical Complaint: feel depressed, already made a schedule with the mental Health need to see mental Health

CONSENT TO TREATMENT:

By signing below, I hereby grant authority to administer and perform routine examinations, treatments of minor illnesses and injuries, medications and diagnostic procedures which may be necessary to address my above medical complaint by physicians, dentists, registered nurses or psychiatrists serving as contract providers or referral. This consent also releases my medical/dental record in whole or part to any outside consultants providing treatment or other services on a referral basis. I also understand that I may be charged a co-pay for medical treatment, which will be withdrawn from my account. I reserve the right to refuse treatment at any time.

Inmate/Detainee Signature _____ Date _____

To Be Completed By Medical Staff Only (Where Applicable)

Staff Response: _____

Subjective: _____

Objective. _____

Assessment: _____

Plan:

spoke c mH 6-22-20, awaiting appt c Psychiatrist

Medical Staff Signature: Hughes, PA Date: 7-1-20

LaSalle Corrections Southeast

MEDICAL REQUEST & CONSENT FOR TREATMENT FORM

Name: 10:00 AM

MAY 12 2020

RECEIVED

Date 05-10-20

Inmate/Detainee Name Andrea Manrique J. ID Number 64401

Unit G1 Date of Birth

MEDICAL REQUEST

Any Allergies to Medication N/A

Nature of Medical Complaint: I need my medical Record, is important for me and my lawyer. Thank you so much for help me!

CONSENT TO TREATMENT:

By signing below, I hereby grant authority to administer and perform routine examinations, treatments of minor illnesses and injuries, medications and diagnostic procedures which may be necessary to address my above medical complaint by physicians, dentists, registered nurses or psychiatrists serving as contract providers or referral. This consent also releases my medical/dental record in whole or part to any outside consultants providing treatment or other services on a referral basis. I also understand that I may be charged a co-pay for medical treatment, which will be withdrawn from my account. I reserve the right to refuse treatment at any time.

Inmate/Detainee Signature Date

To Be Completed By Medical Staff Only (Where Applicable)

Staff Response:

Subjective:

Objective:

Assessment:

Plan:

Take request for records to D/T

Medical Staff Signature: T Hughes LPN Date: 5-12-20

Name: [illegible]

LaSalle Corrections Southeast

MAY 05 2020

RECEIVED

MEDICAL REQUEST & CONSENT FOR TREATMENT FORM

Date 05-04-20

Inmate/Detainee Name Andrea Marrique J. ID Number 64401

Unit C2 Date of Birth [redacted]

MEDICAL REQUEST

Any Allergies to Medication No

Nature of Medical Complaint: I have a heavy pain in my body, in my legs, in my back is so heavy. In my head too.

CONSENT TO TREATMENT:

By signing below, I hereby grant authority to administer and perform routine examinations, treatments of minor illnesses and injuries, medications and diagnostic procedures which may be necessary to address my above medical complaint by physicians, dentists, registered nurses or psychiatrists serving as contract providers or referral. This consent also releases my medical/dental record in whole or part to any outside consultants providing treatment or other services on a referral basis. I also understand that I may be charged a co-pay for medical treatment, which will be withdrawn from my account. I reserve the right to refuse treatment at any time.

Inmate/Detainee Signature [signature] Date 05-04-20

To Be Completed By Medical Staff Only (Where Applicable)

Staff Response:

Subjective:

Objective:

Assessment

Plan:

Has order for tylenol for this

Medical Staff Signature: T Hughes, LPN Date: 5-5-20

Name [signature]

LaSalle Corrections Southeast

OCT 13 2020

RECEIVED

MEDICAL REQUEST & CONSENT FOR TREATMENT FORM

Date 10-16-20

Inmate/Detainee Name Andrea Manique J. ID Number 64401

Unit C.I Date of Birth

MEDICAL REQUEST

Any Allergies to Medication:

Nature of Medical Complaint: I need my medical Record mental health, please all the note with Dr. Faulk, please its urgent. thank you!

CONSENT TO TREATMENT:

By signing below, I hereby grant authority to administer and perform routine examinations, treatments of minor illnesses and injuries, medications and diagnostic procedures which may be necessary to address my above medical complaint by physicians, dentists, registered nurses or psychiatrists serving as contract providers or referral. This consent also releases my medical/dental record in whole or part to any outside consultants providing treatment or other services on a referral basis. I also understand that I may be charged a co-pay for medical treatment, which will be withdrawn from my account. I reserve the right to refuse treatment at any time.

Inmate/Detainee Signature Date

To Be Completed By Medical Staff Only (Where Applicable)

Staff Response:

Subjective:

Objective:

Assessment:

Plan:

See previous

Medical Staff Signature: Date: